

College students' solutions to understanding and treating eating disorders

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Abstract

Introduction: Eating disorders are a public health concern because they are associated with numerous physical and psychological problems. Existing solutions have been explored and implemented with varied success. The present study examined college students' perspectives regarding the type of information and positive solutions to aid in the treatment of eating disorders. People want information about eating disorders beyond the scope of what is currently provided.

Methods: A qualitative study was conducted to understand experiences and perspectives of college students regarding eating disorders and why, despite current solutions, eating disorders are on the rise. Information was collected from ten focus groups using semi-structured interview; constant comparative analysis was used to analyze the data.

Results: Participants' suggestions regarding education included accessible presentations in various formats. Participants also provided solutions on how to address eating disorders.

Conclusions: These solutions included: a family-focused prevention component, adjusting the societal viewpoint, altering BMI requirements on a program level, and providing education on physician-aided support.

Keywords: *eating disorders; public health; treatment; education*

Eating disorders affect individuals across the lifespan; thus, solutions have been implemented and explored. Several treatment options currently exist to aid those suffering from eating disorders, though they have varying levels of success (Aardoom, Dingemans, Spinhoven, & Furth, 2013; Fairburn et al., 2013; Poulsen et al., 2014; Watson et al., 2012). For

instance, cognitive behavioral therapy (CBT) has been found to be highly effective in the treatment of BN (Poulsen et al., 2014), and an enhanced form of CBT has shown recent promise in patients with AN, BN, and EDNOS/OSFED (Fairburn et al., 2013; Watson et al., 2012). Interpersonal psychotherapy (IPT) and dialectical behavior therapy (DBT) are efficacious for the treatment of BED (Wilfley et al., 2002; Telch, Agras, & Linehan, 2001). Adolescent-focused individual therapy (AFIT) and family-based treatment (FBT) are treatment options for adolescent individuals affected by AN that offer considerable improvement (Lock et al., 2010).

Both treatment and prevention have an important role in addressing eating disorders. Successful prevention or education could focus on promoting self-esteem, adjusting society's standards, and encouraging parental and friendship support. Indeed, because less than a third of individuals with eating disorders actually receive treatment, there has been a significant effort devoted to such prevention programs (Fairburn et al., 2000; Johnson et al., 2002; Stice & Shaw, 2004). These programs provide psychoeducational information about eating disorders and their adverse effects, how to resist sociocultural pressures for thinness and weigh-control behaviors, and often target high-risk individuals who exhibit risk factors

shown to predict eating pathology (Stice & Shaw, 2002). Many prevention efforts are focused around education. The important components of education focus on an ecological model for health promotion and seek to modify both the individual and environmental determinants of behavior (Neumark-Sztainer et al., 2009). Education addressing eating disorders may include teacher training, classroom interventions, adding relevant material into current health curriculums in school, individual and group counseling, referral systems, healthy eating opportunities, physical education, and outreach activities (Neumark-Sztainer et al., 2009). A successful general education program that focuses specifically on self-esteem, while placing emphasis upon improving body satisfaction, self-concept, and reducing unhealthy weight loss and dieting practices in adolescents, has also shown considerable improvements in eating disorder risk (O'Dea & Abraham, 2000; Wade, Davidson, & O'Dea, 2002).

counteract societal ideals is through early intervention and prevention programs that encourage awareness for how to identify and reject media manipulations (Thompson & Heinberg, 1999). Another way is through supportive relationships through friends and family that reduce perceptions of appearance-related pressure (Ata, Ludden, & Lally, 2007). Emotionally

supportive, positive relationships are inversely correlated with weight preoccupation (Kenny & Hart, 1992). Additionally, friendship cliques without a focus on body image concerns and dietary restraints are less likely to predict individual body image concerns and eating behaviors (Paxton, Schutz, Wertheim, & Muir, 1999).

While there are many treatment options and prevention strategies available, it is important to determine if people agree that solutions are not only effective, but accessible and pertinent. In order to understand whether or not this was the case, a qualitative study was conducted to provide a new perspective on both treatment options and solutions for eating disorders. This research sought to understand how much information an educated group of individuals knew about eating disorders and current treatment options alongside their opinions on how knowledge of eating disorders should be improved.

The applicable goal of this study was three-fold: 1. To determine if people are aware of current treatment and prevention efforts; 2. To understand if people perceive current options for treating and preventing eating disorders to be effective; and 3. To gather beliefs regarding improvement to prevention and treatment efforts. By having a qualitative

perspective on the existing knowledge regarding eating disorders, researchers may provide personal evidence of the effectiveness and feasibility of current solutions. This knowledge could contribute to improved prevention and treatment by understanding the experiences of those with varying levels of exposure to eating disorders. For instance, despite the fact that medication is generally considered a useful tool during recovery, those struggling with eating disorders may have personal beliefs that prevent them from complying with this type of treatment (Lester, 2014). Thus, this type of information would suggest an increased focus on prevention may be necessary, as empirically validated treatment options may still not be acceptable on a personal level (e.g. valuing and using therapy). The present study used a sample of college students' perspectives in the United States to seek out this information.

Methods

A qualitative study was conducted to understand college students' perspectives on eating disorders. This study used a grounded theory approach in a focus group setting, using semi-structured interviews to gather data. The theoretical foundation supporting this research was the

health belief model, which is a model used to understand and predict the use of the health-related programs or behaviors in human populations (Rosenstock, 1974; Rosenstock, Strecher, & Becker, 1988).

Data was collected from 10 hour-long focus groups of mid-Western university students in the fall of 2014. A phenomenological paradigm was selected to understand and generate ideas and solutions, while targeting knowledge gaps, on eating disorders (Moustakas, 1994). The researchers aimed to learn about the participants' opinions by listening to their statements and seeking to understand the basis for each participant's different responses. In this study, focus groups provided a facilitative group environment in order to explore participants' perspectives and allow researchers to gather data (Knafl & Howard, 1984). The interviewer was a graduate student who was studying counseling and therapy who was able to empathize and understand the students, while making them feel comfortable to discuss their ideas. Questions were structured (e.g. what are eating disorders, the causes, the risk factors, and treatment) to allow specific responses, while still encouraging prompts and general ideas to come to fruition.

Audio records of each interview session were transcribed, and codes were manually extracted based on the conceptual framework of a phenomenological study as described by Moustakas (1994), focusing primarily on current knowledge and treatment of eating disorders. Codes

appeared as ideas that were common across interviews and then underwent constant comparative analysis; these codes focused on understanding eating disorders and why current treatment options may not be enough, warranting supplemental programs and education for the future. Eight main codes were generated out of the constant comparison and made into a codebook. Themes were then generated from the codebook. Six themes were identified under an overlying “solutions” code; themes included “knowledge,” “prevention,” “parents,” “societal ideals,” “program level,” and “addressing current eating disorders.”

Validity concerns exist in qualitative research. In order to address some of these concerns, the researchers attempted to establish credibility, as well as employed peer debriefing and reflexivity (Hays & Singh, 2011). Peer debriefing occurred during the writing, reviewing, and developing of interview questions. Reflexivity occurred during coding and included thoughts on the participants and general participant reactions to the questions asked. In addition, the researchers sought to establish credibility, which focuses on the authenticity of data gathered in order to ensure meaningfulness and accurate interpretation. Because those leading the focus groups were college students of similar age to the participants,

credibility was enhanced, as participants may have been more comfortable sharing their perspectives with those who they considered to be peers.

Triangulation was achieved by include multiple participant perspectives to also add to the validity of the data.

Participants

There were 10 focus groups ($n = 43$) including undergraduate ($n = 35$) and graduate students ($n = 8$) that were recruited via on-campus flier from a single university in the Midwest. Participants ranged in age from 18 to 36 ($M = 21.81$, $SD = 4.39$). The majority of participants identified as White (90.7%; $n = 39$), middle class (86%; $n = 37$), heterosexual (95.3%, $n = 41$), single (72.1%; $n = 31$), and female (76.7%; $n = 33$). The majority of participants (88.4%; $n = 38$) had experience with eating disorders. Within that group, participants had experience through a variety of avenues (note: some indicated multiple sources of exposure) including the self (31.6%; $n = 12$), a parent (10.5%; $n = 4$), a sibling (13.2%; $n = 5$), another family member (23.7%; $n = 9$), a female friend (78.9%; $n = 30$), a male friend (10.5%; $n = 4$), someone in the media (28.9%; $n = 11$), or a co-worker (10.5%; $n = 4$). Participants responded similarly to a question about their current knowledge of eating disorders, and responses ranged from 1 to 10

($M = 6.71$, $SD = 2.34$). All participants gave full written informed consent.

The study was approved by the Institutional Review Board at North Dakota State University in 2014.

Results

Findings from the focus groups are presented below under the main headings of “solutions,” which we believe best answered the questions in the study. The “solutions” findings were then organized into additional sub-themes that described possible resolutions regarding knowledge, education, and treatment of eating disorders.

Solutions

The participants in this study provided solutions on how eating disorders should be addressed. These solutions included prevention with a strong focus on parenting and family togetherness; additional solutions included adjusting the societal viewpoint and altering BMI requirements on a program level. The final suggestion was directed at individuals with eating disorders and focused on providing education on professional treatment options, as well as encouraging the use of friends and family as a helpful support system during recovery.

Knowledge. Participants provided opinions on their own personal knowledge gaps regarding eating disorders alongside ways to disseminate

information on the topic. Participants believed that better education about eating disorders needed to be addressed before solutions could be implemented. Participants acknowledged the importance of providing better education to a widespread audience in order to support the future implementation of solutions.

Participants expressed a strong need for additional educational material on eating disorders; they believed that this information should be provided in junior high or middle school “especially around prepubescent and pubescent age” (P15). It was generally believed that information on eating disorders should be provided earlier than most participants had received it, which was typically in high school; furthermore, participants suggested information should be significantly expanded upon, since it primarily focused on definitions or physical attributes of eating disorders. Research supports this idea, as the median age of development of eating disorders has been found to be around ages 12 to 13 (Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). Participants believed that supplemental information would help them understand potential risk factors, the causes and treatment of disorders, and how to approach sensitive situations with individuals who have eating disorders. This

information could have been provided in a more creatively educational way to help people understand eating disorders through “eye-witness documentaries” (P40) or other means “that... diary people’s personal experiences” (P17).

While participants integrated information on eating disorders that they had previously been exposed to in school, such as definitions and the grade in which they initially learned about eating disorders, they were fairly clear that they would have preferred more. The depth of knowledge wanted on eating disorders went beyond obvious definitions, “not just telling people the definition of what each disorder is, but to explain, like, what it does to you physically and mentally” (P22). The preferred information and education on eating disorders spanned from “how to deal with it better” (P40) to changing society’s norms, “there should be an emphasis on respect and not judging other people and not making any assumptions about their health based on their appearance” (P32).

Prevention. Suggestions regarding prevention of eating disorders included various components. Some suggestions promoted positive self-confidence and self-understanding alongside improved parental or “prevention instead of crisis care” (P42). Participants also believed that personal satisfaction and understanding of one’s own abilities were primary

important role of parents in the development of eating disorders, supporting participants' ideas. For instance, research has shown that girls who believe that they are criticized by parents about their food intake are more likely to have poor body image, and mothers who restrict their girls' and boys' food intake have children who are significantly more likely to use extreme weight control behaviors (Cooley, Toray, Wang, & Valdez, 2008; Loth, MacLehose, Fulkerson, Crow, & Neumark-Sztainer, 2013). By changing parent behavior, it is indeed possible to help reduce future maladaptive behaviors and beliefs in children (Hart, Cornell, Damiano, & Paxton, 2014).

Participants believed that educational information needs to be relayed to families, and considering the large influence that parents have on their children, the dissemination of that information is crucial. Some of their suggestions included providing “more information in like parenting classes” or “take-home stuff, where it’s like, parents need to sit down with their kids... they’re required to talk about it even though it’s awkward and weird”

(P9). Having these discussions may lead to parents modeling healthier behaviors as well, “to set a good example for [their] kids” (P14).

Societal ideals. Some participants discussed the need to challenge societal ideals regarding body image. These suggestions focused on “draw[ing] the attention away from my body image and more into like what I’m capable of” (P16). Other ideas focused on the societal view and how we treat ourselves and others; these suggestions included “the acceptance of others and acceptance of yourself” (P1) and how “complimenting someone can be a good thing... it doesn’t necessarily have to be about their body” (P12). It has been shown that fat talk, which includes supposed “compliments” such as “You look great, have you lost weight?” increases the body dissatisfaction of those participating in the conversation (Salk & Engeln-Maddox, 2012). One final suggestion centered on how society can change its standards, for example, “maybe do away with the bikini thing in the pageants... pageants are really good in terms of education and you know, their different platforms that they have. And that’s great, but do we have to have the bikini contest, too?” (P1).

Program level. Some participants believed that attitudes regarding risk factors and eating disorder treatment needed to be addressed on a

program level. Acceptable levels to be admitted into therapy were discussed, “they were like, your levels aren’t bad enough for purging, so you can’t go to the program... ‘Oh, I’m not good enough, like, I am not sick enough’” (P41). There is indeed a general trend towards admitting patients with lower BMIs than there has been in the past, and it has been shown that patients who begin treatment at lower BMIs are more likely to have to be re-admitted for further treatment later on (Sly & Bamford, 2011).

Participants suggested that the way eating disorders are treated within the medical system should be encompassing of both mental and physical aspects.

.. it really highlights for me just how the medical model is so much, like, crisis mode. Let’s just look at the physical. Do you have a certain weight? Do you have medical complications, like ulcers or tears in your esophagus?’ ... it’s a bandage. What about the spiritual aspect of your life? What about your occupational functioning? Like, are you able to go to work? To school? ... hope is such a powerful thing, but if all we look at is just the physical... I don’t see much success in that. So, being able to explore, like, other parts of a person’s life to help them develop... just to find the hope in your lives,

so you can create a different identity that is not bound up by what this disorder wants for you (P42).

Indeed, in America, it was found that length of time spent in an inpatient program decreased from 150 days in 1984 to 24 days in 1998 (Wiseman, Sunday, Klapper, Harris, & Halmi, 2001). This trend, due in part to the switch from private insurance coverage to health maintenance organizations (HMOs) that are less likely to cover extensive psychiatric inpatient care, has been seen throughout the country, resulting in the medical community's lowering of treatment expectations during inpatient stays, particularly when it comes to addressing mental health concerns (Kaye, Kaplan, & Zucker, 1996; Treat et al., 2005). These noted patterns among the medical community indicate that participants may be correct in suggesting that current inpatient treatment programs, due to the forced decrease in time for treatment, are mostly addressing the physical, not emotional, aspects of disordered eating.

Addressing current eating disorders. Participants provided suggestions for individuals who currently know or suspect that they know someone who is affected by an eating disorder. The relationship to the person struggling was important to consider according to participants, "I

think it's really important for friends and roommates to get involved. And family" (P11). Similarly, participants had suggestions about how individuals should be approached regarding their eating, including the importance of conversation and "talk[ing] to them first" (P33). Participants believed in providing positive feedback to the person, telling them "what I say is coming from a place of love and support, not from judgment" (P42) and "You're not the only one" (P1). They also suggested "encourag[ing] them to get treatment since there are professionals that can deal with it better than I can" (P21). Professional care was important because "the long-term effects" (P11) would be discussed. Other suggestions included reiterating the importance of self-love; they suggested to "try to help them embrace who they are and love it" (P29) and to try "building their confidence" (P29).

Discussion

Eating disorders, including anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and other specified feeding and eating disorders (OSFED, similar to the previous diagnosis of EDNOS, Eating Disorder Otherwise Specified), occur frequently among both males and females. A recent study of lifetime prevalence of DSM IV eating disorders

determined that approximately 5% of U.S. women will have an eating disorder in their lifetime, as will over 2% of men (Duncan, Ziobrowski, & Nicol, 2017); these percentages are most likely higher, as the DSM V criteria was established in 2013 and men are likely to be underdiagnosed, describing Anorexia Nervosa as a disorder that “primarily affects girls and young women” (American Psychological Association [APA], 2013).

In addition, all eating disorders have an elevated mortality risk (Smink, van Hoeken, & Hoek, 2012). In disability adjusted life years—or a measure of disease burden expressed as years lost from morbidity or mortality—there are 5.1 deaths per 1,000 person years due to AN, while 1.74 deaths per 1,000 person years are attributed to BN and 3.31 deaths per 1,000 person years are due to OSFED (Smink, van Hoeken, & Hoek, 2012). Furthermore, in a recent study, for those that sought out clinical treatment, individuals with AN were over five times more likely to die compared to the general population, while those with EDNOS were almost 2.5 more times likely to pass away (Fichter & Quadflieg, 2016). Those with BED and BN were approximately 1.5 times more likely to die than those in the general population (Maximillian, Fichter, and Quadflieg, 2016). These numbers also do not account for those suffering from eating disorders who

never seek professional treatment or eating disorder specific treatment. In addition, the most common unnatural cause of death in the aforementioned study was suicide; while the majority of AN patients that passed away did so from natural causes (approximately 89%), those with other eating disorders were far more likely to die by suicide (Maximillian et al., 2016). More specifically, Maximillian and colleagues (2016) found that 5 out of 10 BN patients that passed away did so due to suicide. Thus, these mortality rates confirm the importance of understanding the causes and treatments of eating disorders.

Furthermore, while clinical eating disorders in adults are often the precursors to eating disordered behaviors (e.g., body dissatisfaction, drive for thinness, fear of becoming fat, restrictive eating) that begin to develop in early childhood. For instance, one study found that not only are over 35% of ethnically diverse 9-and-10-year-old girls dissatisfied with the sizes of their bodies, but 7 to 11% of those children already qualified as anorexic (Deleel, Hughes, Miller, & Theodore, 2009). In addition, a study of 5-to-8-years-old girls and boys found that 35% of boys wanted a thinner figure, compared to 59% of girls (Lowes & Tiggemann, 2003). This is highly concerning, as Evans and colleagues (2017) recently found that the

presence of such disordered symptomology in childhood was the strongest predictor of continued disordered eating in adolescence.

There are many programs, prevention, and education efforts that exist regarding eating disorders, but do these types of solutions align with what people need, want, and find effective, and are individuals aware of those solutions? This study sought to answer these questions. Ultimately, answers from participants determined some alignment as well as some inconsistencies with what types of programs are available for eating disorders and what options should be made available. For example, current education includes healthy eating and physical education, but participants believed that knowledge for treatment, support systems, and general knowledge on eating disorders needed to be included in education as well. Some preventative and educational measures suggested by participants do align with empirical evidence, but there are many other solutions that participants seemed unaware of, such as available treatment options for people with eating disorders are primarily therapy programs (e.g., individual and family, cognitive, interpersonal, etc.). While they may not be perfect, these programs can be successful, so there is a need for a greater understanding of the effectiveness of these options. The majority of eating

disorder sufferers do not seek out eating disorder specific treatment, perhaps partially due to the negative beliefs regarding the medical treatment of eating disorders described by current participants; increasing awareness of those successful treatment options may lead to an increase in treatment seeking.

That said, responses from participants in this study primarily focused on an upstream approach involving educational information and prevention practices for eating disorders. An upstream approach in public health is centered on prevention, while downstream efforts include treatment. Education and prevention were important to participants; they proposed increasing access to effective educational information by including presentations in various formats, such as documentaries, as well as by including parents in the discussion, such as by requiring schools to send home materials on eating disorders. Information beyond basic definitions was requested to be provided in junior high or middle school, which is consistent with research suggesting that eating disorders often develop in early adolescence (e.g., Swanson et al., 2011). Current health programs are available in schools, but focus mostly on healthy eating, physical education, and outreach; however, as suggested by the participants, this

type of information, as well as details on eating disorders, should continue to be disseminated throughout high school. This sustained education can create a lasting foundation that can be utilized in college, a time when eating disorder development is common, but by which the risk factors, such as a desire to have a thinner body, have already had years to develop (Damiano et al., 2015; Keel & Forney, 2013).

Participants also suggested taking more of an organic approach to eating disorder prevention and education, by using family and friendship support systems, parenting-specific prevention information, and addressing standards on a macro-viewpoint, such as BMI requirements. Other suggestions were directed at individuals with eating disorders and focused on providing them with education on physician-aided support, as well as the importance of support from friends. Unfortunately, peers are often examined in the literature as risk factors, not protective factors. For instance, it has been shown that peers choose to be around others who exhibit similar personality characteristics, and that among these selected peers, there is a socialization effect on BN where symptoms increase as peers are together and decrease during periods of separation (Zalta & Keel, 2006). Furthermore, perceived pressure to be thin and criticism from

peers were related to disordered eating symptom development for girls and boys in late adolescence (Shomaker & Furman, 2009). However, Prouty, Protinsky, and Canady (2002) found that women in college indicated that they were more likely to ask for and want support from friends rather than parents or college officials, indicating the importance of educating everyone, so that friends of those suffering are able to respond in supportive ways. Unfortunately, there is currently still stigma surrounding the causes of and risk factors for eating disorders, and without better education, people may unintentionally give advice that they perceive to be supportive, but that is ultimately harmful for the individual suffering (Mond & Arrighi, 2011).

Ultimately, suggestions focused on the importance of eating disorder education and how the public could better position help individuals before they would need to enter treatment. By changing public understanding of the risk factors for eating disorders through the use of a public health perspective, we can strive to prevent eating disorders before they develop instead of attempting to treat them afterwards. A more informed and knowledgeable society, along with more directly involved individuals, such as teachers, parents, and friends, could help with providing education, a

support system, and a more comprehensive model for the prevention and treatment of eating disorders (Stice, Becker, and Yokum, 2013). The goal is that everyone will not only understand the origin of eating disorders but be able to help prevent the onset as well as personally discontinue harmful attitudes and behaviors that may contribute to another's eating disorder.

The answers and suggestions from participants confirm the need for the dissemination of more information specific to eating disorders. As it stands, participants believed that there is a gap in information regarding understanding and treating eating disorders, leading to increased stigmatization and reduced help seeking. These alternative perspectives contribute to the knowledge base regarding resources that may be helpful for people dealing with eating disorders, either personally or through a loved one. This research sought to understand how much information an educated group of individuals knew about eating disorders, their opinions on how if current treatment options are effective, and whether this information aligned with current practices on eating disorders. The applicable goal of this study was to yield improved solutions on basic understanding and current prevention and treatment of eating disorders and body image issues. This information can ultimately be used and

implemented by educators, policy makers, and practitioners in order to develop more encompassing, long-lasting solutions.

There were a few limitations to this study. Our sample size primarily included White participants of middle-class socioeconomic conditions in the United States. Furthermore, focus groups, in general, have many potential limitations associated with them, which includes difficulty discerning answers and associating the correct participant with answers, lack of participation due to shyness in a group setting, and dialogue that can be off-topic. Finally, possible transcription errors may have occurred as well, though two to three people listened and checked recordings and transcriptions to reduce the chance of error.

Conclusion

Perhaps the most important finding in this study highlights this idea: Creating and disseminating the most effective prevention efforts and treatments may rely on the development of a culture that understands the risk factors, signs, and treatment options of and for eating disorders. Knowledge alone may not be enough to encourage those suffering to actively seek out treatment, but culture and family environments paired with

appropriate knowledge can help predict positive body image outcomes (Becker et al., Haworth-Hoepfner, 2000). If those suffering from eating disorders are unaware of the success of treatment options, afraid to access those options without support from friends and family, or fear stigmatization from loved ones for their disorder, then the disease can progress and become worse.

Eating disorders are prevalent in the United States in both males and females; moreover, eating disorders have significant impacts on public health as only approximately 17 to 31% of those suffering ever actually receive the eating disorder specific treatment that they need, treatment is expensive and is seen as a financial burden, and many still do not fully recover even if they have the financial means to seek specific help (Berkman et al., 2007; Cachelin & Striegel-Moore, 2006; Hart, Granillo, Jorm, & Paxton, 2011). Not only does eating disorder specific treatment place a financial burden on both the sufferers and those around them, but in lieu of treatment, sufferers utilize health care professionals to deal with the various side effects of their disorders and find it difficult to function both socially and physically (Mond, Hay, Rodgers, & Owen, 2007; Mond, Hay, Rodgers, & Owen, 2012). Current solutions focus on treatments that are

high in costs and low in availability; therefore, they do not effectively incorporate a public health aim to include the general population, rather than only a small proportion of the affected population. Incorporating an approach towards the prevention of eating disorders could ultimately encourage better preventative strategies and policies (Sánchez-Carracedo, Neumark-Sztainer, & López-Guimerà, 2012). The suggestions provided by this research can be used in the future with current treatment programs. The combination of effective prevention and treatment options, alongside a more knowledgeable culture, could both help to address the public health issue of increasing rates of eating disorders in the United States.

Conflict of Interest to Declare

The authors have no conflicts of interest to disclose.

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